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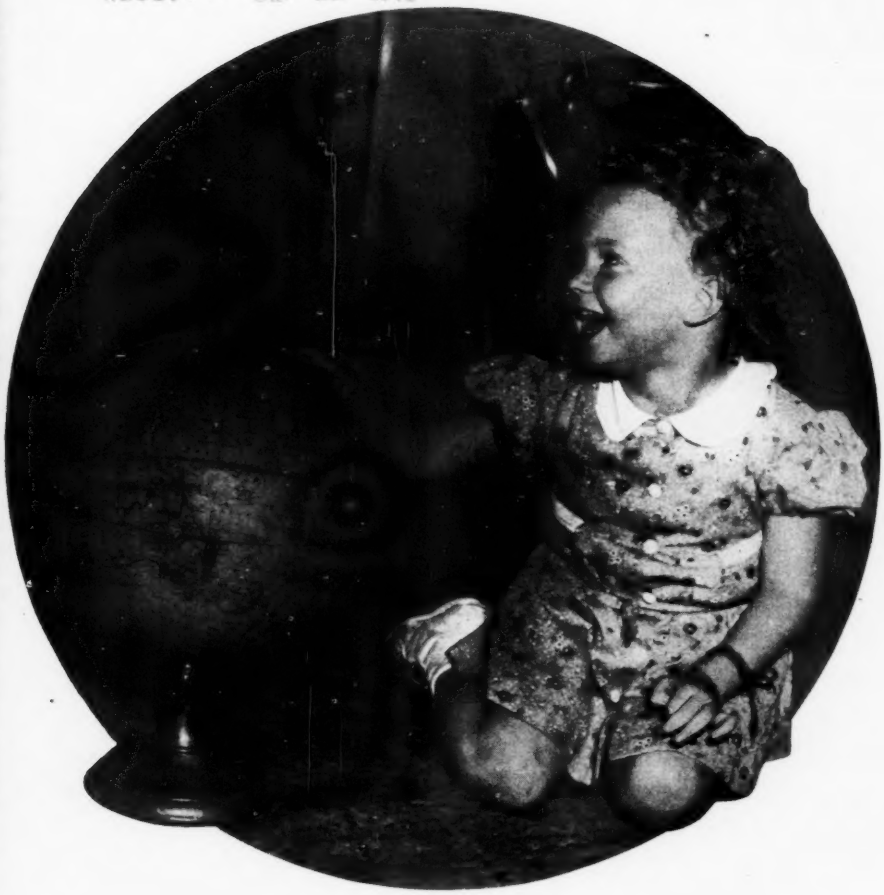

The CHILD

U.S. CHILDREN'S BUREAU • U. S. DEPARTMENT OF LABOR

Child-Welfare Workers Prepare for I. L. O. Meeting

Emotional Aspects of Convalescence

Accidents Still Take Their Toll of Young Workers

VOL. 10 • NO. 2 • August 1945

The CHILD

MONTHLY BULLETIN

Editor MIRIAM KEELER

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The photograph on the cover is used by courtesy of the Indiana Department of Public Welfare.

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU

NATIONAL BACK-TO-SCHOOL DRIVE UNDER WAY

"A quarter of a million more boys and girls enrolled in high school this fall than last" was announced on August 7 as the goal for this year's Back-to-School Drive, sponsored by the U. S. Office of Education, Federal Security Agency, and the Children's Bureau, U. S. Department of Labor.

The appeal this year is being made in particular to teen-agers who are in summer jobs, those who have been laid off from full-time jobs, and those who are still in school but thinking of dropping out to get a job. These young people are being urged to stick by their No. 1 job of completing their high-school courses, so that they will be prepared for postwar job opportunities and citizenship responsibilities

Backing the drive, besides the Children's Bureau and the U. S. Office of Education, are the Office of War Mobilization and Reconversion and the Advisory Council of the Retraining and Reemployment Administration. This council includes representatives of Government agencies dealing with manpower problems.

High-school enrollment reached its all-time high in 1940-41, when the number of students enrolled was 7¼ million. For 4 years, war pressures have pushed enrollment down and child labor up. Enrollment dropped 300,000 in 1941-42; 300,000 in 1942-43; 600,000 in 1943-44. Only a negligible drop occurred in 1944–45, thanks largely to the 1944 national Back-to-School campaign. The 1945 drive is expected not merely to maintain present school enrollment but to build it up another quarter million over last year's.

Some of the shrinkage in high-school enrollment has been due to a decrease in the number of boys and girls of high-school age. Most of it has been due to the great increase in youth employment. In the spring of 1945 nearly 3 million were employed. Half of them had dropped out of school entirely. Half were in part-time jobs. (No count is available of the number of youngsters under 14 who are working and not in school.) Some of the 1½ million youths of high-school age who have left school and are in full-time employment may be laid off as cutbacks occur. They are an important pool of potential new students.

Another source of new recruits is the pool of summer workers. In each of the three summers (1943, 1944, 1945) between 4 and 5 million high-school age boys and girls have been at work during vacation. The temptation in the fall to stay in jobs and forego school is enormous. Summer employment undoubtedly contributed to the serious drop in school enrollment in the fall of 1943. The 1944 Back-to-School campaign helped greatly in pulling back to school the boys and girls who had taken jobs. The 1945 campaign is directed again to these summer workers.

Even at the peak of high-school enrollment in 1940–41, some 600,000 students stopped their courses at the end of the ninth, tenth, or eleventh years. Only 60 out of every 100 who entered the ninth grade completed the twelfth year. During the war these drop-outs have greatly increased.

Educators throughout the country are being asked to take the lead in organizing their communities for Back-to-School drives. Last year's experience shows that when all groups in the community take hold, boys and girls can be persuaded that their best interest lies in completing their high-school education. Along with the effort to get the boys and girls into school, educators are being urged to reexamine their programs and courses to strengthen the long-time value of education. Programs that have been geared to wartime conditions must now be readapted to meet the peacetime needs of youth.

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CHILD-WELFARE WORKERS PREPARE FOR I. L. O. MEETING

Exchange news about children's needs at Montreal conference

by KATHARINE F. LENROOT

Chief, U. S. Children's Bureau and representative of the United States at Montreal

Child-welfare experts, one from each of 10 countries and two from Canada, together with representatives of the United Nations Relief and Rehabilitation Administration and of the American International Institute for the Protection of Childhood, met in Montreal, Canada, from May 23 to 30 at the invitation of the International Labor Office to advise the Office in regard to the preparation of material for discussion at the International Labor Conference to be held in Paris this fall. The representative of the United States, who is a member of the International Council of the American International Institute for the Protection of Childhood, also represented the Institute.

This meeting was particularly notable because it was the first specialized international gathering in which officials responsible for the health and welfare of children and the protection of young workers in the Western Hemisphere had the opportunity of conferring with representatives of recently liberated countries. Difficulties involved in travel arrangements delayed the arrival of the representatives of France and the Netherlands until very late in the session, but they and the representative of Belgium gave graphic accounts of the plight of children and youth in those countries and the measures already in operation or projected to assure them greater opportunities and fuller protection. The delegate from China drew a picture of the immensity of the tasks of child protection and child care in his country. He is returning to China to assist in a project for training 8,000 social workers, including 1,500 child-welfare workers, for immediate wartime service.

Photograph by United Nations Relief and Rehabilitation Administration

REPATRIATING LITTLE CITIZENS like these brave troopers who have lived out the war in Egypt requires much more than a one-way ticket back to homes in war-torn European countries. Wherever possible UNRRA gives them the skilled help of child-welfare workers in making the journey back and the adjustments at home easier.

In addition to the material prepared by the International Labor Office and that presented by the delegates, reports and messages were received from the International Bureau of Education, the Conference of Allied Ministers of Education, and the Interim Commission on Food and Agriculture.

The group elected as its chairman Dr. G. F. Davidson, Deputy Minister of National Health and Welfare of Canada, and as vice-chairman Dr. Paula Alegria, Chief of the Office of Women and Minors of the Ministry of Labor and Social Insurance of Mexico. Inasmuch as the chairman was able to be present for only the first 3 days and the last day, much of the discussion was guided by Dr. Alegria.

Six of the members of the group (from Canada, Belgium, France, Mexico, the United Kingdom, and the United States) were connected with national departments of labor; three were or had been connected with Government departments of welfare or of health and welfare (Chile, China, Canada); three (Chile, Peru, United States) were the heads of Government services for children. In addition, a member of the Governing Body of the International Labor Organization, Dr. Rego Monteiro, who was until recently the Director General of the Ministry of Labor of Brazil, attended many of the sessions and contributed greatly to the discussions.

In opening the meeting, the Acting Director of the International

Labor Office, E. J. Phelan, said in part:

The question of the welfare of children and the protection of young workers was placed on the agenda of the Conference by the Governing Body; that is, by the 16 Governments represented and by representatives of employers and workers. The Governing Body considered it an urgent question; it is not a new one for the International Labor Organization and various aspects of it have been considered since 1919, but the approaches made have been fragmentary—single questions were considered and decisions taken, a method suitable to times of peace. The Governing Body decided that on this occasion the question should be discussed as a whole in its wider aspects, and was led to this decision by the gravity of war problems in all countries; for example, in China, where exists the greatest problem of displaced persons ever known in the history of the world, many of these persons being children and young persons; in Latin America, whose economy has been distorted by war; in the United States and Canada, where important changes in family life have been caused by the departure into the armed forces of millions of men and by extensive employment of women in factories.

These problems must be brought into a general perspective, and for this reason the Office has called together experts from various countries and from official international organizations also interested in this subject. The International Labor Organization has no monopoly of ideas nor of action. The Paris Conference will consider a resolution on general principles. After this comprehensive review, it will be seen which parts should be carried forward by the International Labor Organization and which ones by other organizations. In 1946 the Conference may have to consider those particular points of the resolution which would appear to be appropriate for early action by the International Labor Organization.

It was stressed by the acting director that the meeting was for the purpose of exchange of views without any restrictions and that these views do not commit the Governments of the countries to which the experts belong. Guidance was sought for the preparation of the report to the Conference, which is the responsibility of the Office. In closing, Mr. Phelan stated that the political decisions of the San Francisco Conference and the technical decisions of the Paris Conference would be meaningless unless, in this critical period, the problems of children and young persons are dealt with successfully.

Mme. Marguerite Thibert, Director of the Division of Women and Children of the International Labor Office, amplified the remarks of the acting director regarding the purpose of the meeting. According to the instructions of the Governing Body, Mme. Thibert said, the Office is to prepare a draft resolution to be presented to the next International Labor Conference. The resolution should formulate general principles on child protection in relation to the child's preparation for his future role as a citizen and worker and on the protection of nonadult workers. She referred to the constitution of the International Labor Organization adopted in 1919, which included among the aims of the organization the abolition of child labor and the imposition of such limitations on the labor of young persons as will permit the continuation of their education and assure their proper physical development. She also referred to the Declaration of Philadelphia (1944), which recognizes the solemn obligation of the International Labor Organization to further among the nations of the world programs which will achieve provision for child welfare and maternity protection, and assurance of equality of educational and vocational opportunity.

The importance of coordination of measures was recognized in Mme. Thibert's statement. It was implied in the instructions of the Governing Body that the resolution should lay out a general plan which formulated the principles of social policy for children. Many aspects of these questions are of equal interest to other international organizations; as regards some, other organizations are better equipped to define methods or to undertake practical action. When an outline of principles has been formulated, each international organization could take as its province the carrying out of some particular point of a general program planned for the well-being of children, Mme. Thibert reported that two matters to come before the next International Labor Conference deal with medical examination for the admission of young persons to employment, and with prohibition of night work for young persons in nonindustrial employment.

The International Labor Office has prepared a statement as a basis for discussion. Before this was taken up there was general discussion of the work of the committee, followed by brief reports of conditions in each country represented on the committee and one by the representative of the United Nations Relief and Rehabilitation Administration. It was decided that the points of view expressed in the discussions, as recorded in the minutes, would constitute the record of the meeting and that no special statement by the committee would be prepared nor would formal votes be taken on the points under discussion, since the purpose of the committee was to exchange ideas and inform the Office on the material to be presented to the Paris Conference. Subcommittees, however, drew up material for a preamble dealing with the urgent needs of children and young persons in the countries most affected by the war and with the organization of health and welfare services.

High points in the reports on conditions in countries represented on the committee included the following:

In recently liberated countries: Serious conditions of health and education are reported, rising infant mortality, loss of weight in children, destruction of schools, lack of school equipment, difficulties during the occupation in maintaining effective services for children. The United Nations Relief and Rehabilitation Administration has found that in general in liberated countries the most urgent needs are for food, clothing, medical supplies, fuel, and shelter. As for children, one of the most serious problems is that of homeless and displaced children, of whom a considerable number cannot be identified or are of unknown nationality. Active efforts are being made by the Governments to reestablish, improve, and coordinate services for children. Plans in Belgium include the creation of a General Youth Commissariat, an official body with a triple function, advisory, coordinating, and executive, in regard to the matters not within the jurisdiction of any ministry.

In China: It has been estimated that there are in China 84 million displaced persons, of whom many are homeless children. The Government has set up or subsidized 599

institutions, which care for 200,000 children. Twenty thousand industrial cooperatives care for half a million refugee children. China is predominantly an agricultural country, in which more than 80 percent of the population is engaged in farming. There is strong emphasis on the family, on the importance of the child, and on public responsibility for child welfare.

In the United Kingdom: During the war all social services have continued, though with depleted staffs, and all protective legislation has been enforced, with some modifications. There has been no appreciable increase in the employment of school children. Legislation on hours of employment and prohibition of night work for young persons has been relaxed but kept under control. Emergency orders allowed specified relaxations. Wartime measures relating to the employment of young persons are being carefully revised. There has been great development in communal feeding and improvement in medical and nursing services and in the organization of personnel management. It is proposed to overhaul the social-insurance scheme, and the establishment of children's allowances is being considered.[1]

The new Education Act provides for the gradual raising of the age of admission to industry to 15 and 16 and for continual education for everyone up to 18 years of age. A Government committee is studying the situation of homeless children.

In Canada and the United States: Problems affecting the welfare of children in wartime, some of them involving serious social losses, have led in the United States to plans for expansion of maternal and child-health services, with Federal aid; measures to extend and strengthen social-security systems; strengthening of Federal and State child-labor laws; and recommendations on the establishment of State and local children's commissions or councils to promote a more coordinated approach to the problems of the child. In Canada several plans affecting social policy have been proposed. Definite progress has been made in social security; in family allowances, which went into effect in July of this year; and in the establishment of provincial departments of health and welfare in all provinces not previously having such organizations.

In Latin-American countries: In some countries geographic, racial, and linguistic differences between regions accentuate problems of child health, education, welfare, and employment. Extension of schools is helping to promote a common language. Great progress has been made in education, in the extension of health and social services, in the regulation of child labor, and in the development of governmental services of broad scope for children. Good child-labor legislation is not enough to solve the problems of children, considered not only from the technical, but from the human point of view. As was stressed by the representative of Mexico, only the coordination of services and the unification of social, medical, educational, and labor programs can give the child adequate preparation for the struggles of life.

The "Basis of Discussion" prepared by the International Labor Office included consideration of general social problems concerning children and young persons, including maintenance of children and health and social protection; education; vocational guidance and training; apprenticeship; problems concerning the admission of children to employment, including minimum age, employment and work permits, placement, and social insurance; and problems concerning protection of young workers, including hours of work, night work, wages, safety and hygiene, supervision and control, and other matters. Questions of administration were also included. A subcommittee drew up material on social policy concerning young persons, with special reference to the problems of children and young persons in countries especially affected by the war. A subcommittee on social and health protection drew up a statement for the use of the Office in drafting material on this subject.

In discussing questions of administration, differences in point of view regarding the relative advantages of unified as against coordinated administration of children's services were expressed. All agreed that suitable administrative arrangements would necessarily differ from country to country, depending on political structure, the historical development of various programs, and other factors. There was agreement also on the need for harmonious and comprehensive laws as well as a means for coordinating administration. Adequate administrative systems, with necessary specialization, and a unified social policy of child protection are essential.

The International Labor Office, after reviewing the minutes of the meetings of the committee, is preparing a draft resolution and a report for the next International Labor Conference. The title "Youth Charter," originally proposed for the resolution, was dropped in favor of a somewhat more restrictive title, which would indicate that the scope of the proposed Conference resolution was for the most part to be confined to employment matters.

In closing the meeting, Mr. Jef Rens of the staff of the Office said:

> A meeting like this one is among the most interesting of those held by the International Labor Organization. There are no high-sounding phrases and empty words, but a sincere and valuable exchange of views which gives fruitful results. We are especially grateful to the experts from the liberated countries who have made us understand the living conditions of children in their native lands.
>
> The wide experience that experts from Asia, Europe, and both North and South America have brought to the meeting will be of the greatest value to the Office in the preparation of the resolution, and it is hoped that the result will be a document acceptable to nations in every part of the world.

●

On June 30, 1945, the Governor of Illinois signed a new child-labor law, which will become effective 6 months after the end of the war. Among its more important advances the act includes a 16-year minimum age for work during school hours in manufacturing establishments, canneries, laundries, restaurants, and several other types of establishments, as well as a limitation of 3 hours a day on school days for work of minors under 16 years of age employed outside school hours.

[1] An act establishing children's allowances was passed in June. See p. 22.

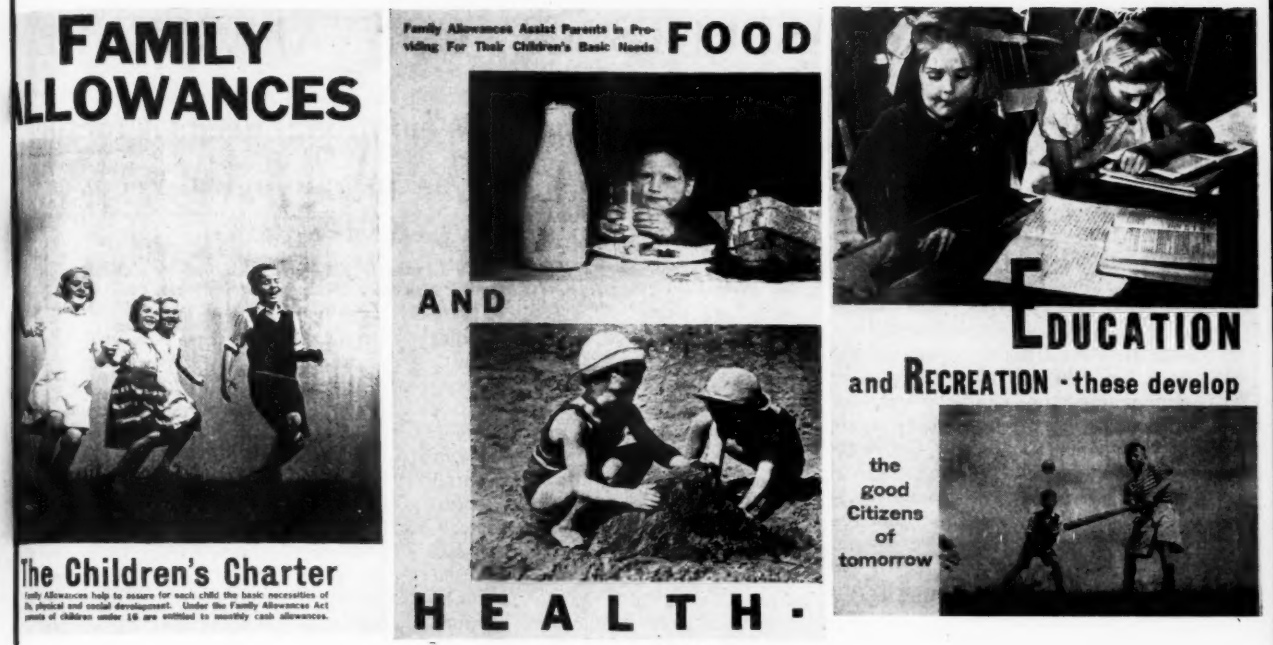
NEW FAMILY ALLOWANCE ACTS COMPARED

Prior to its adjournment in June 1945 the British Parliament passed a Family Allowances Act, providing for monthly payment by the Government to British families on behalf of each child in the family except the first. This act is one of the measures proposed in the Beveridge report in the hope of establishing a comprehensive social-security program in England, and its passage may be regarded as a first step in the implementation of the Beveridge report. (Also of direct benefit to children is the passage of the Education Act, remodeling the structure of the school system and making provision "for family allowances to be supplemented through supplying free milk and meals to school children on a scale that will ultimately cost £60,000,000 a year.") *London Times, June* 16, 1945.

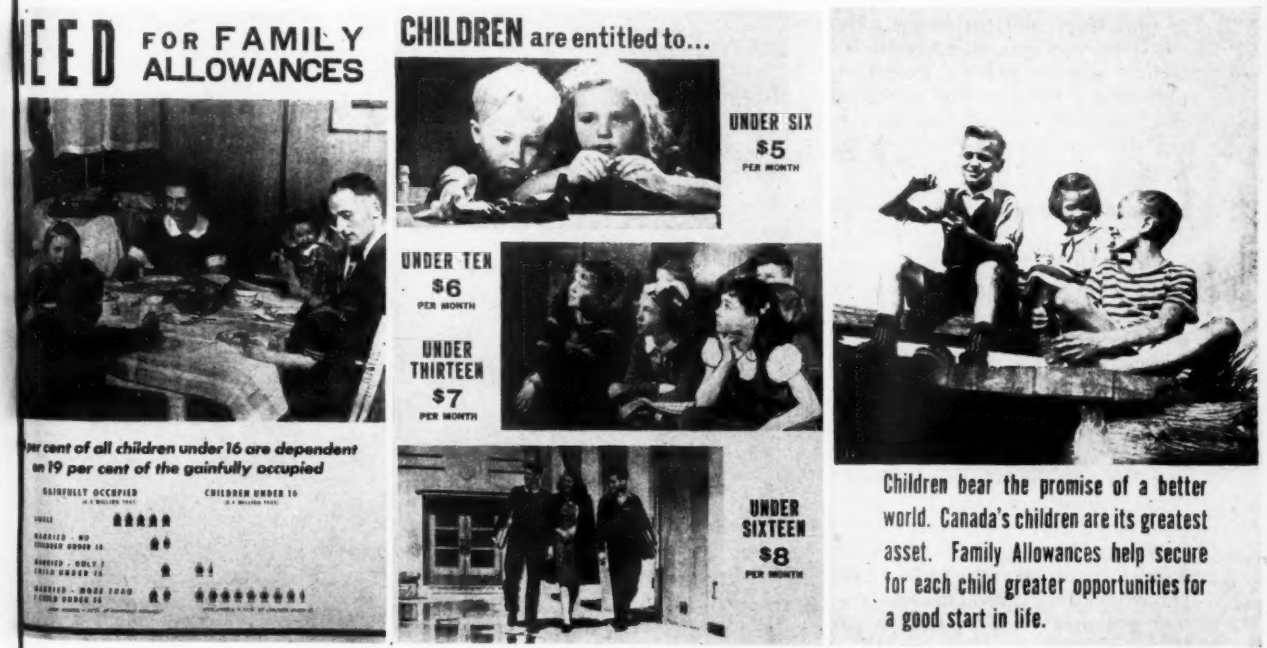
The British Family Allowances Act is similar to the Family Allowances Act of Canada, which was passed in August 1944 and became effective July 1, 1945. These acts are an attempt on the part of the Governments to lighten the burden of child support, especially those in large families. Both the British and the Canadian plans provide for regular payments from general Government revenues to families with children. The intention of the Canadian act is stated as follows: "The allowance shall be applied by the person receiving the same exclusively towards the maintenance, care, training, education, and advancement of the child." The British act describes the purpose of the allowance to be "for the benefit of the family as a whole." Actually this difference in emphasis is likely to be of little significance in the use of the funds.

Both England and Canada have incorporated the administration of the family-allowance acts into newly organized Government departments. The British program will be administered by the Ministry of National Insurance; and Canada's program is placed in the Department of National Health and Welfare, where it is administered in the Welfare Division.

	GREAT BRITAIN	CANADA
ELIGIBILITY		
	All children, except the oldest in the family, eligible until they reach upper age limit for compulsory schooling (15 years), or until the August after their sixteenth birthday if they are still in school or receiving apprentice training.	All children under 16, except that children over 6 and under 16 are eligible only if attending school.
POLICY REGARDING DUPLICATION		
	1. Children for whom orphans' pensions are paid do not receive family allowances; nor do children receiving equivalent benefits in connection with the parent's military service or war injury.	1. In order to prevent duplication, family allowances may be reduced or withheld in consideration of other benefits paid to the family by the Canadian Government. No such reduction or withholding, however, may be made in the case of children of servicemen who are receiving benefits in connection with the parent's military service.
	2. Reduced family allowance is granted if person is receiving funds under outdoor relief, unemployment assistance, or old-age or widows' pensions.	2. Bonus for dependents under unemployment-insurance plan not affected by family allowances. Family may receive benefits for child under both laws.
	3. Income-tax deduction for children continued; family allowance is taxable income.	3. Allowance not subject to taxation under income-tax law, but income-tax deduction for child is decreased by the amount of the family allowance received. Family has option of applying for allowance or for tax deduction, whichever would benefit it most.
PAYMENTS		
	Five shillings a week for each eligible child. (Approximately $1 a week in United States currency at present rate of exchange. This does not, however, take into account the greater purchasing value of money in England.)	Payments vary according to age of child and number of children in family as follows: *Age of child* — *Monthly allowance* Under 6 years.... $5 6-9 years..... 6 10-12 years..... 7 13-15 years..... 8 Reduction of $1 per month for fifth child in family, of $2 for sixth and $2 for seventh, and of $3 for eighth and each additional child.
	Statute says that allowances belong to wife, but are receivable by either man or wife if they are living together	Payment may legally be made to either parent. Determination of recipient left to Provinces, and, according to reports, all payments are made to mother.



THIS SET OF SIX POSTERS shows how the Canadian Government informs families about the Family Allowances Act. Copies of the posters may be had without charge by writing to the Canadian Wartime Information Board, 1205 Fifteenth Street NW., Washington 5, D. C.



EMOTIONAL ASPECTS OF CONVALESCENCE

Fulfillment of child's emotional needs is factor in physical as well as psychological recovery

by MILTON J. E. SENN, M. D.

Associate Professor of Pediatrics in Psychiatry, Associate Attending Pediatrician, New York Hospital and Cornell University Medical School, New York City

In the history of a sick person it is not easy to say when convalescence begins nor when it ends. It is equally difficult to differentiate between the physical signs and symptoms which belong to an illness and those which are part of its reparative process. Similarly, an appraisal of the emotional aspects of convalescence introduces perplexities. Despite the difficulties in delineating the boundaries of convalescence and in enunciating the characteristics of that period, an attempt will be made in this paper to describe the reactions of infants and children who are recovering from physical illnesses, to discuss the forces and motives underlying the emotional responses, and finally to mention some of the psychotherapeutic aids which are useful in treating sick children and in promoting recuperation.

Child a living, changing person

In a consideration of illness and of returning good health it is important that the child be considered as a living, changing person whose mind and body jointly share in the progress of recovery and in the process of growth. An interplay of the forces of physiology and pathology, influenced by endogenous psychological factors and by various exogenous phenomena produce the emotional reactions, and since all these powers are dynamic the resultant feeling tones are moving and changing.

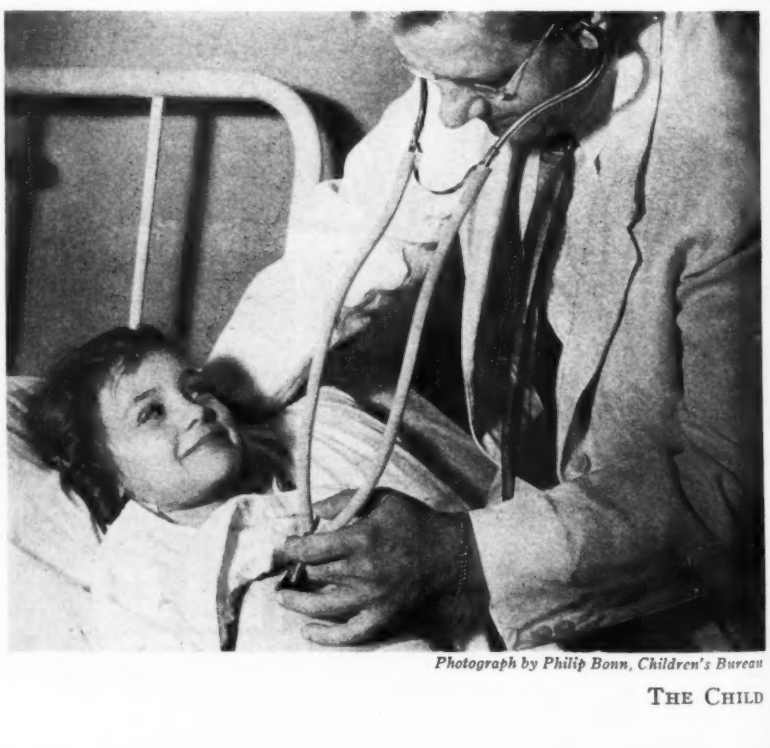
Dominant emotion in illness important

While in general it may be said that a child in illness and convalescence is experiencing the same emotions as in health, and on occasion may be happy, worried, optimistic, depressed, fearful, anxious, hopeful, resentful, and so on, it must be pointed out that his dominant prevailing affective state is of greatest concern. In illness and convalescence this may be quite different from that demonstrated in health. The difference may be due to a specificity of the disease process. This occurs most frequently in persons who have pathology of the central nervous system and may be illustrated in patients with general paresis, whose predominant emotional state is that of euphoria, or instances of brain trauma and encephalitis with fearlessness in defiance of authority as the dominant characteristic mood. But in these patients with disease of the central nervous system, as in all other sick persons, there is a nonspecific emotional response as well.

At one time it was thought that the area of the body which housed the pathological organ determined the mood of the patient; for instance all diseases of the thorax were supposed to produce euphoria, while those of the abdomen resulted in melancholia. It was also held that certain illnesses always brought forth explicit mental states, as for example pulmonary tuberculosis, which was supposed to produce a more or less continuous feeling of exaggerated optimism and hopefulness. It is now recognized that the disease processes are not the preordaining influences, but that various psychological factors predicate the emotional response of each person when he is ill and as he gets well.

The emotional response of a sick child to his illness and convalescence

THE PHYSICIAN who consciously tries to avoid producing physical fear, who is attentive to the timing of his therapy in terms of the psychological as well as the physical needs of the patient, who does not deceive his patients, and who takes the time to listen to their doubts and fears and to answer their questions exerts powerful influences of reassurance which prevent psychological complications of illness.



Photograph by Philip Bonn, Children's Bureau

is dependent on various important factors. These may be enumerated as follows:

1. The physical, intellectual, and psychological status of the individual at the onset of his illness. This is largely determined by what went on before in his growth and development, beginning with conception, and in life experiences from birth onward, especially in terms of relationships with parents and siblings in the specific cultural milieu in which he was reared.

Prenatal influences

It is very important to remember that one does not begin as a human being at his birth. We are increasingly cognizant of the fact that prenatal influences, psychologically and physiologically, have a great importance. We also must remember that the health of the mother, emotionally, with her interest in her coming child, is of tremendous importance, because there may begin to be during pregnancy a very close emotional bond between mother and child. That is the place for it to begin, and it is the place for the pediatrician to begin to think in terms of the child not only as a physical being, but as one who has personality and who is closely tied emotionally to his mother.

2. The nature of the illness. The acuteness, type, severity, and duration of symptoms, the length of convalescence, and the amount and kind of physical residua are important items. The character of the medical and surgical management is included in this category.

3. The meaning of the illness to the patient. This includes consideration of the attitudes of the sick child during the period of ill health and of his preexisting feelings about body, health, disease, and life in general.

4. The interpersonal relationship of patient and nurse, and of patient and physician. This includes attention to the personalities of the medical and nursing staffs caring for the child as much as to the personal characteristics of the sick person.

Factors overlap

Although there is overlapping of these factors, discussion will be centered about each item with emphasis on its relatedness to the others.

Assuming that the patient has normal intelligence and has been able to use optimally the opportunities for growth and development in the area of reasoning, learning, and remembering, the state of his physical and psychological being at the beginning of his illness constitutes the first important determinant as to how he will react to the changes in his body. Such things as the degree of dependency on his mother and the methods of parental management in meeting the attempts at self-assertion and self-expression in the child's strivings for independence and in training him to new habits will influence his emotional reaction to the illness which interrupts his growth. The infant who is physically dependent on his mother for food feels close to her psychologically as well. If the nature of the disease is such as to demand new and different eating habits the baby experiences fear of separation from his mother as well as fear of new methods of feeding, and this may produce a train of gastrointestinal symptoms which in turn cause feelings of discomfort and pain and emotional states of hostility, anger, irritability, and frustration.

A psychological lag

Convalescence may begin physically through excellent medical and surgical care but often is delayed and prolonged while there is a lag psychologically because the infant cannot accept with satisfaction the substitute feeding regime which may be ideally suited to him from the standpoint of nutrition and physiology. The pediatrician frequently sees such a baby, who won't eat well or gain weight while in the hospital, turn about and eat heartily and joyfully when fed by his mother in the home.

Two-year-old both dependent and independent

The child of 2 years who has reached a point in his development where he feels ambivalent toward his mother, wanting to be independent of her yet at the same time feeling very dependent, often shows his dilemma by an aggressiveness of action, as if he were trying out his powers of independence. He expresses this aggressive attitude with some misgivings, however, feeling threatened by the loss of his loved parent, even though the latter may never have menaced him with such a punishment. When illness comes to such a child, he is apt to relate it to his sentiments, and if treatment demands removal from the parent he is overwhelmed with emotions of guilt and of fear of permanent separation from his loved ones. Here again, physical convalescence may be slow and irregular while the child shows mixed attitudes and behavior, often characterized by acts of aggression, hostility, or defiance or by withdrawal into submissiveness and undue placidity, all with a strange undertone of anxiety, fear, and resentment. Even after return to home and parents, such children may carry over feelings of fear, as if expecting a recurrence of separation.

Some children predisposed to emotional change

The emotional responses of children to mild upper-respiratory infection have been described by Richter.[1] Twelve children ranging in age from 5 to 14 years, most of them adolescent, developed syndromes of anxiety, depression, and compulsive-obsessivephobic thinking and acting within 1 month after the onset of mild symptoms of "cold" or "grippe." The psychological phenomena lasted from 6 to 9 months after the physical illness was over. Specific etiological factors were not determined, but it is interesting that each child had similar personality characteristics before his illness, as if to denote that there was a personality predisposition to the emotional changes. All the children who developed the disease had been docile, subservient, cowed by authority, perfectionistic in their strivings, and meticulous in personal habits; as a group they were repressed and nonaggressive and possessed qualities which were valued in society. It seemed that in health these children had difficulty in expressing their hostile feelings, but with illness the barriers were lowered and the individuals responded with aggressive thoughts and acts, although during the sickness each child interpreted illness as "punishment" for some supposed naughtiness or wickedness.

[1]Richter, Helen G., M. D.: Emotional Disturbances of Constant Pattern Following Nonspecific Respiratory Infections. Journal of Pediatrics, Vol. 23, No. 3 (September 1943), p. 315.

This group of case histories is interesting because the emotional display shown here is seen frequently in adolescents, who normally have strong feelings of right and wrong, who are fearful of body change and misinterpret even slight deviations of development as significant of great pathology, related somehow to acts of omission or commission. The case summaries of Richter are important too in pointing out the duration and lag of psychological convalescence in comparison to the physical recuperation.

Sudden illness may cause emotional shock

In considering the second important determinant of a child's emotional response to physical illness and convalescence, attention is focused on the nature of the illness. One which strikes with suddenness, demanding immediate change of setting without benefit of psychological preparation, such as in a disease warranting immediate hospitalization and operation, stimulates feelings of uncertainty, confusion, fear, and anxiety; these result frequently in emotional shock, which persists for a long time in the period of recovery. Symptoms of such a condition, which has also been called "fright neurosis," are those of general irritability, sleeplessness, night terrors, and attacks of anxiety, with vasomotor and secretory disturbances. These symptoms are well recognized by surgeons, who attribute delays in postoperative recovery to their severity. Finney[2] has pointed out the importance of adequate psychological preparation in reducing the incidence of these emotional reactions. A detailed description of the process of assimilating anxiety which prepares a person to withstand a surgical operation is given by Deutsch[3] in a paper on psychoanalytic observations in surgery.

In his autobiography, Finney talks about a man that needed an operation. He was examined and was sent to the Johns Hopkins Hospital, and when it came time to operate he was found to be very disturbed, with a mood of restlessness and hypertension, and the operation was postponed. It was postponed for several days, but this restlessness did not disappear. He came back again and was again found to have hypertension and to be distraught, restless, and fearful. He was sent home. He returned the third time. This time, when Dr. Finney saw him, he did not have hypertension; he seemed quite at ease, and Finney thought it was strange, and by accident he talked to the porter.

The porter said, "You know, it is a funny thing with that man in the room; when he came into his room he began to be very upset, and as I walked in I said, 'Gee, you are a lucky fellow.' He said, 'What do you mean?' I said, 'You have got Finney for your doctor,' and he said, 'Why is that lucky?' And I said, 'You know, Finney seldom loses a case.'" After that the man did not seem so restless, and Finney thought that this porter's reassurance had been the specific psychotherapeutic aid that put the man at ease.

Location of illness significant

In the discussion of how the nature of the illness affects the emotional response, mention must be made of the fact that the location in the body of the pathological changes and their permanency in making the child different from his peers are very significant. An infant or young child will not feel embarrassed by disfigurement of face or deformity of extremity even though his parents will have strong emotional reactions of guilt and unhappiness and may transmit to him some of their feelings. However, as the child grows older his handicap may bring forth a spectrum of emotional display, especially of self-pity, anger, resentment, and unhappiness. His response may be furthered by physical protest or by emotional repression, and if it is primarily the latter there will follow by virtue of conversion mechanisms a new train of physical-psychological symptoms, especially headache, dizziness, abdominal discomfort, and gastrointestinal manifestations, which dominate and prolong convalescence and interfere with therapy until psychiatric assistance is provided the patient and is accepted by him and his parents. Another group of children who react similarly because of the nature of their illness are those with cerebral palsy, who demonstrate great fear of falling and of being dropped, and who improve physically and mentally only when able to become relaxed and trusting in the hands of persons who, they feel, love them.

What illness means to the child

Then there is the third item in our outline; namely, the meaning of the illness to the child. So far, stress has been placed on the fact that illness may be a threat to a child. It may suggest a fear of separation from loved parents or from life itself. It may threaten his security, his life's ambitions and dreams, or his way of looking at himself admiringly.

If his response to threatening life situations has customarily been one of defiance, he will probably react to illness and convalescence with contempt, and he will be disposed to resist the attempts of others to help him get well. He opposes the assistance of medical and nursing staffs and of social workers, preferring "to see things through" by his own design, as if the whole episode were a test of his capabilities as a person. Convalescence for such a child may be irregular, with fluctuations back and forth as he prematurely attempts to take up normal activity. The child with heart disease, for example, when he begins to feel better often resists restraint and tests out his own notions as to management. It is important then that the recommendations by the medical and nursing staffs should be based on sound physiological and and psychological reasoning, lest the child's experiments disprove their validity and increase his skepticism and resistance.

One is reminded of the advice given occasionally to such a child that if he were to perform a certain act, so-and-so would follow. Challenged and feeling defiant, he carries out the forbidden activity, and when no apparent harm follows and the predicted results do not appear the child loses trust in his medical adviser and formulates further his own

[2]Finney, John Miller Turpin, M.D.: A Surgeon's Life; the autobiography of J. M. T. Finney. G. P. Putnam's Sons, New York, 1940. 396 pp.

[3]Deutsch, Helene, M.D.: Some Psychoanalytic Observations in Surgery. Psychosomatic Medicine, Vol. 4, pp. 105-115 (January 1942).

ideas of medical management. One example of an unphysiological response to theoretically sound advice is furnished by a child known to us who has bleeding tendencies and who was told that he must move around little lest he start bleeding. This boy's reaction was one of fear to the point of developing external involuntary motor restlessness, which increased his anxiety still more because it provoked further demands of complete rest from his physicians. A further response in this patient was fear of bleeding to death at night, so that he slept fitfully. He was reassured only when told that nurses would look at him often during the night. Feeling ashamed at being different from his fellow patients, this 10-year-old boy also rationalized his state by claiming to have originated during infancy power to bleed at will. As one got to know him in the hospital, his true feeling was acknowledged; namely, that he considered his present illness as punishment for something "bad" he had done earlier in life.

What can we do for this child as a child?

We all know the child who develops marked restlessness when complete bed rest is suggested. In two children's hospitals in this country I saw a boy and girl, interesting examples of this. First, a girl of 10 was admitted in the springtime because of Sydenham's chorea. She was admitted one week after the onset of her illness, which came suddenly when her father deserted the family. In the hospital the child was very active. She was given phenobarbital in increasingly larger doses, and it did not do any good. The next fall at a staff meeting an intern, who had come on in July and inherited this child who had been admitted in the springtime, brought up for discussion the question of how to care for this child further, because that morning she was found sitting on a window ledge threatening to jump out and commit suicide because she objected to staying in the hospital and because of the fact that her mother was allowed to visit but once a month, and the question that arose at the staff conference was: How can we sedate this child further?

Why was this child objecting to the hospital stay? What more could we do for this child as a child? When it was suggested that the problem was not one of sedation, but rather one of looking at the child and seeing that her needs were fulfilled, we soon developed a child who was very quiet and very happy and who was discharged very soon.

Sedatives failed

The second case was a boy of 8. When I was making the rounds with the staff one day, the question of what to do with him came up, because he was a boy of great motor restlessness, especially in the early evening. This boy, too, had been admitted because of chorea, which had never subsided even though increasing amounts of sedative had been given. In the evening, when the children were supposed to go to sleep, this boy became still more overactive and restless, and the problem was: Shall we change from phenobarbital to bromo drugs, or what drugs shall we substitute? There was some discussion about that, and an intern stood up and said, "I have something to admit. I am very worried about something. This boy is my patient. He has been a great problem to me. He has been annoying to me, and last night, when he was supposed to go to sleep, I hauled off and hit him in the face. I am very sorry for this. I would like to make up to him now, I would like to do something. I have not done right by him. This boy has two requests that he keeps making. One is that he be allowed to wear a brown suit." (The boy, being at rest, was not dressed. He had not been given a hospital jumper, which was a brown suit, like the other patients.) "The other request," went on the intern, "was to be allowed to be up on the roof during the day. We have not given him that privilege because we are afraid that he cannot stand it, because his heart won't take it. I would like to try stopping the phenobarbital and give him a bromo and have him go up on the roof and see what will happen." That was done, and after a few days this boy was absolutely quiet and was discharged and has had no recurrence of chorea or of cardiac or other rheumatic manifestations.

In contrast to children who respond to illness with resistance, there are others who reply with feelings of pleasure. It is quite likely that in all of us pleasure is mixed with pain, and that illness may foster emotions of relief and joy after initial feelings of pain and displeasure, and that convalescence may offer surcease from a life of struggle and turmoil. This is expressed in modern psychiatry as "the secondary gain" of illness. The sick person finds that his reliance on others for special care and for protection is enjoyable, much as it was in early childhood and infancy, and he may consciously and unconsciously prefer to prolong this state of dependency rather than return to good health and the obligations of normal living. Children with such feelings often regress too in their habits of eating, toilet training, and sleeping. Only when health holds greater compensation than illness will they give up invalidism and special privileges, and even then they will continue to reflect on the illusory advantages of being sick.

Child's response depends on adults

This paper has so far been concerned with the personality reactions of sick and convalescent children, but it must be emphasized that their emotional responsiveness is dependent in some degree on the personal characteristics of the adults who take care of them. The conscious, and especially the unconscious, tendencies of parents, physicians, nurses, and other workers in close contact with infants and children leave marks upon their psychological performance and development. Any restlessness, fussiness, apprehension, irritability, as well as optimism and joy, will be communicated to them. Previously mention was made of the fact that sick children often regress in their habits to an infantile level. In this state of dependency they look for mothering from medical and nursing staffs as from parents, and if a happy transference relationship is set up between the ailing child and an adult who acts as a parent-substitute, a reestablishment of health may follow rapidly. On the other hand, a prolongation of convalescence may ensue if the child fears that once he is better he will lose this new, loving

parent or if the nurse does not realize that a strong emotional tie has been set up, which must gradually be deflected back towards the real parents. A nurse, as a professional person, like the mother should know herself thoroughly so that she may watch her reactions and understand the role she is playing, lest unwittingly she foster undue dependency through the exercise of what on the surface appears to be very good nursing care.

Relation between patient and physician

The interpersonal relationships of patient and physician also evoke feelings in the ailing child. The role of the physician is variable, and he too becomes a parent-substitute, a person of authoritative function, a hero, and even an individual with magical power. As a member of a committee on admissions to a medical school, I am impressed by the number of candidates who date their interest in medicine as a career to the time when certain physicians took care of them. On the other hand, one sees children under therapy in a psychiatric clinic who date their neurotic illnesses to frightening episodes in physicians' offices and in hospitals. Psychological evidence shows that painful memories linger in the background of the mind and reappear from time to time as fear of many things. The physician who consciously tries to avoid producing physical fear, who is attentive to the timing of his therapy in terms of the psychological as well as the physical needs of the patient, who does not deceive his patients, and who takes the time to listen to their doubts and fears and to answer their questions exerts powerful influences of reassurance which eventually lessen the period of convalescence and prevent psychological complications of illness.

One is naturally led at this point to mention other psychotherapeutic aids which are useful in promoting good health and recovery from sickness. There should at some point be mentioned the values of different dwelling places for a convalescent child. For some, especially the infant and young child, the home will stand out as the most ideal if the necessary physical treatment can be carried out unhampered. If hospitalization or placement in a convalescent home is indicated, that place should resemble the normal home life as much as possible. Home is extremely personal; the hospital atmosphere should simulate the home in this regard.

Infants and children should be permitted to keep the ties with parents and home through regular visits, and the older children in addition should be permitted to keep up indirect communication through mail and telephone messages. On admission to a hospital, social-history data should be obtained from parents as to family relationships, individual toilet habits, toilet idiosyncrasies, eating methods, food dislikes, and so on in order that all who plan for the child in his new residence may more easily make it resemble his permanent living conditions.

Trained social-service workers are able to help family and child bridge the gap between home and hospital through interviews before admission, and especially at the time of admission. These workers, through continuous contact with the child in the period of hospitalization, may help him to maintain a sense of belonging to his family even though he is away. Like anyone else in the group who cares for the patient they may be chosen by him to function as depositories for the inner feelings which arise in the child at each change in hospital routine.

Adolescent welcomes freedom

The adolescent often welcomes the opportunity to leave his family and benefits by separation because it represents the emancipation which he is striving to accomplish. If those who attend him have reached a maturation of personality development so that they are able to treat him as an individual in his own right, he will attempt to emulate their manner of living as adults without the feelings of ambivalence which usually surround relationships of adolescent and parent.

With each patient, attempts should be made to foster a feeling of stability. Frequent uprootings of residence in even such minor changes as shifts of bedrooms add to potential feelings of apprehension and prevent bonds of friendly attachment from developing which are so essential for promoting security.

It is understood that knowledge of the healthy infant and child must be had before one can deal, adequately with the sick and convalescent. Without this information one does not know what goals are to be sought in the restorative processes, nor what reactions of thinking and acting are to be expected from each individual. Much of this information will come from parents, or from the children as they play.

Play

In children, play is a natural medium for communication. It permits a child to tell us things about himself as a person, his physical abilities, and his feelings. It enables him to try out physical energy, to experiment with newly discovered endowments, and at the same time to gain something psychotherapeutically as he relates his experiences and emotions to others. It brings relaxation and rest, diverts the mind from stress, and acts as a safeguard against the development of undesirable habits such as excessive thumb-sucking, masturbation, and day-dreaming, through providing opportunity to express tension, anger, and resentment. Opportunities for diversional and occupational play should be provided each child in keeping with his physical, intellectual, and emotional needs. Bedside and group instruction for school-age children also should be available so that the child may develop a satisfaction of achievement comparable to that experienced by his peers who are in full activity and whom he may join on a level of equality in accomplishment when he returns to school.

In this paper, attempts have been made to present the emotional aspects of convalescence as moving forces, related to the changing physical states of a child growing in a constellation of other individuals. Convalescent care was described in terms of dynamic mechanisms with the aim of restoring physical function and mental well-being and of preventing as much as possible all psychological and somatic residua.

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ACCIDENTS STILL TAKE TOLL OF YOUNG WORKERS

Nine States report startling wartime increases in injuries

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One of the striking features of the war period is the great increase in industrial injuries to minors under 18 years of age. In part this reflects the tremendous rise in youth employment, both legal and illegal, that has occurred, with the accompanying increase in exposure of boys and girls to accident and health hazards on the job.[1] In a large part, however, it is due to the fact that, whether or not they are legally employed, young workers tend to have a higher accident-frequency rate than adults in comparable occupations. This is because they are usually inexperienced and also because they are just young—more adventurous, less mature in judgment, and less responsible than older persons.

Because no Nation-wide estimates of the number of industrial injuries to minors under 18 years of age are available, it is necessary to search for these data in the statistical reports issued by State workmen's compensation commissions and departments of labor. Only a minority of the States tabulate information showing injuries to workers in this age group. In this minority, however, are a number of the larger industrial States. The figures published in these reports are usually based on industrial-accident and occupational-disease cases reported by employers and insurance companies to the appropriate State agency for the purpose of complying with the State workmen's compensation law. In no State do the statistics include all injuries occurring on the job. At best they include only those injuries that come within the scope and coverage of the State workmen's compensation law. No two State compensation laws are alike. This means that the statistics on industrial injuries are not comparable between any two States, even when similar terms are used.

What State Statistics Show

Recent statistical information available for nine States—Illinois, Maryland, Michigan, New Jersey, New York, North Carolina, Ohio, Pennsylvania, and Wisconsin—show a remarkable upward trend in injuries to workers under 18 years of age. (All nine States include minors illegally employed within the coverage of their workmen's compensation laws. All but two of these States—North Carolina and Ohio—provide additional compensation for minors injured while illegally employed.) In one of these States the rate of increase between 1940 and 1943 was 1,100 percent; in another, more than 1,300 percent. But let each State tell its own story.

Illinois.—The number of compensable industrial injuries to minors under 18 years of age reported to the Illinois Industrial Commission rose from 282 in 1940 to 1,867 in 1943, an increase of 562 percent.

For the group under 16 years of age the number of reported injuries was over five times as great in 1943 as in 1940—141 as compared with 26. Even children under 14 years shared in the increase, for only 2 of this age group were reported injured in 1940, compared with 31 in 1943.

Injuries to 16- and 17-year-old boys and girls rose from 256 in 1940 to 1,726 in 1943, an increase of 574 percent.

Maryland.—Workmen's compensation claims filed by minors under 18 years of age with the Maryland State Industrial Accident Commission numbered nearly four times as many in 1944 as in 1940, rising from 200 in 1940 to 772 in 1944.[2] Children under 16 years of age, most of them either 14 or 15 years old, filed 10 times as many claims in 1944 as in 1940—73 as against 7. The 16- and 17-year-old workers filed 699 claims in 1944 compared with 193 in 1940, an increase of 262 percent.

Michigan.—According to the most recent quarterly statistics published by the Michigan State Department of Labor and Industry, the number of compensable cases reported for minors under 18 years of age rose from 330 in 1942 to 1,027 in 1943, an increase of 211 percent in a single year. The total for the first 9 months of 1944 alone, during which 849 cases of injuries to minors were reported, represented an increase of 157 percent over the entire year 1942.

New Jersey.—Industrial-injury statistics for New Jersey represent the number of compensated cases closed in any given year. For all minors under 18 years of age the number of cases closed nearly trebled between 1940 and 1943, rising from 308 to 893. Most of this increase occurred among the 16- and 17-year-old workers. In this age group the number of cases closed rose from 283 in 1940 to 827 in 1943, an increase of 192 percent.

For children under 16 years of age the number of cases closed in 1940 was 25; in 1943 it was 66. Most of these youngsters were either 14 or 15 years old, although a few (2 in 1940 and 6 in 1943) were under 14 years of age.

New York.—The year 1942 is the latest for which State-wide data on the total number of injuries to minors under 18 years in New York have been published. Some indica-

[1] Census estimates indicate that the number of minors 14 through 17 years of age at work increased from less than 1 million in March 1940 to nearly 3 million in April 1945. During the 1944 summer vacation period about 5 million were employed.

[2] The 1940 figures represent the year from November 1, 1939, to October 31, 1940; the 1944 figures represent the calendar year 1944.

tion of later trends, however, at least as far as accidents to illegally employed minors are concerned, is given in the following statement made by the State department of labor:

> Along with the greater use of youngsters in the labor force and the sharp increase in the number of child-labor violations there has been a startling rise in the accident rates of children. In New York State the number of accidents to minors employed illegally has increased sevenfold since 1940. The State workmen's compensation law provides that where minors under 18 are employed in violation of the labor law compensation for accidents to them is double the amount otherwise payable. Such double-indemnity cases in New York State increased from 48 in 1940 to 346 in 1943.[8]

In the New York City compensation district alone, awards of double indemnity for accidents to minors injured while illegally employed numbered 33 in 1941, 95 in 1942, 289 in 1943, and 548 in 1944. These tremendous increases are ascribed by the New York State Department of Labor to the wartime increase in illegal employment of minors.

North Carolina. — Unpublished figures on injuries to minors in North Carolina under 18 years of age have been made available to the Children's Bureau for the year ended June 30, 1943, and the year ended June 30, 1944. They represent the number of compensable cases reported to the North Carolina Industrial Commission during each of these 2 years.

In the year ended June 30, 1943, the total number of compensable injuries to minors under 18 years of age was 341. In the following year it was 547, an increase of 60 percent in 1 year alone.

For the group under 16 years the number of compensable injuries rose from 28 in the earlier year to 52 in the later year. Most of this increase took place among children 14 and 15 years old. Nevertheless 5 of the 28 injuries reported during the earlier period and 12 of the 52 reported during the later period involved minors under 14 years of age. The age ranged down to 10 years in 1943 and to 11 in 1944.

[8]Child Labor in Minimum Wage Industries, Summer 1943. Bureau of Research, Division of Women in Industry and Minimum Wage, New York State Department of Labor. Albany, 1944. 10 pp. Processed.

Ohio.—The most recently published statistics on industrial injuries to Ohio minors under 18 years of age are based on the number of claims filed with the Ohio Industrial Commission. The figures include injury cases in which no time was lost in addition to cases involving loss of time, other types of disability, or death.

In 1940 the number of industrial-injury claims filed by minors under 18 years of age was 1,177. In 1943 this figure rose to the astounding level of 14,127, a number 12 times as great, representing an increase of 1,100 percent.

The greatest proportionate increase occurred among minors 16 years old. Their claims rose 1,670 percent—from 306 in 1940 to 5,417 in 1943. The next largest proportionate increase—971 percent—was among the 17-year-old workers, the number of whose claims rose from 713 in 1940 to 7,639 in 1943.

Children under 16 years also showed a heavy increase in number of claims. In 1940 they filed 158 claims, and in 1943 the number rose to 1,071. This was an increase of 578 percent.

Among the children under 16 years of age who filed claims in 1943 were 117 who were not yet 14 years old. Of these 117 children, 60 were 13 years old and 57 were still younger. In 1940, claims were filed for 10 children 13 years old and 6 under 13.

Since accidents involving medical expense only, with no loss of time, greatly outnumber those causing death or some type of disability, the Ohio figures are much larger than they would be if they excluded, as a number of States do, those injuries that are not compensable under the State compensation law. Ohio has, however, recently compiled unpublished data showing the number of "lost-time" and other disabling injuries for minors under 18 years of age, based on claims filed during 1944. These total 4,007 for all workers under 18 years of age, 447 for children under 16 years, and 3,560 for workers 16 and 17 years old. Forty-seven children were under 14 years of age, of whom 17 were under 13 years and 30 were 13 years old. No comparable data are available on this basis for other years.

Pennsylvania.—Like Ohio, Pennsylvania shows a startlingly high increase between 1940 and 1943 in industrial injuries to young workers. Injuries reported for minors under 18 years of age numbered 354 in 1940. In 1943 they totaled 5,115. This represents a rise of 1,345 percent. Injuries to workers 16 and 17 years old accounted for most of the increase, for in this age group the number of injuries rose from 317 in 1940 to 4,764 in 1943, or 1,403 percent.

Injuries reported in 1943 for children under 16 years—most of them either 14 or 15 years old—were nearly 10 times as many as in 1940—351 as against 37. For the age group under 14 years the number of injuries reported in 1943 was 17, compared to 3 in 1940.

Wisconsin. — Industrial-injury statistics in Wisconsin are based on compensable cases of injury settled during a given period. In 1940 the number of cases settled involving minors under 18 years of age was 124. In 1944 it was 1,297—10 times as many as in 1940.

The number of compensable cases settled for minors under 18 years of age who were illegally employed rose from 37 in 1940 to 257 in 1944. Although this obviously reflects a large increase in the number of children illegally employed in Wisconsin, it does not necessarily mean that the proportion of illegally employed minors has increased. In fact, the proportion of injury cases of illegally employed minors to the total number of injuries to workers under 18 years of age declined from 30 percent of the total in 1940 to 20 percent in 1944.

Putting Facts and Figures to Work

Statistics and stories picturing the accident and health hazards to which young workers are exposed, are much needed in all States. It is not enough to learn how many accidents occur, but also how, where, and why they happen. What industries, what jobs, what specific kinds of activity on the job appear to cause injuries to young workers? How severe are these injuries? Are the working conditions of these boys and girls in line with State and Federal child-labor laws, with safety and

health laws, and with good practice? Do these young people need more training, better supervision?

Accurate statistics on industrial injuries, collected, tabulated, and analyzed periodically in forms useful to those who need them, are a fundamental tool for appraising the effectiveness of child-labor laws and other legislation intended to protect the health and safety of young workers. Especially desirable are statistics showing injuries to minors illegally employed separately from those occurring to minors legally employed. Statistics on those illegally employed would indicate where the enforcement of the present laws protecting young workers needs to be strengthened. Statistics on those legally employed would give clues as to how the existing laws or regulations need to be improved in order to prevent children from being employed on jobs that are too dangerous for them. They would also be useful in determining which jobs are so hazardous that employment in them ought to be forbidden for minors who are old enough for general employment. This would be especially helpful in those States in which a State agency has been given authority to prohibit the employment of minors in especially dangerous occupations.

For case stories of industrial injuries to minors illustrating specific accident and health hazards, the individual report of injury is usually the best primary source of information. Such a report is ordinarily required for every industrial injury within the scope of the State workmen's compensation law, and is filed with the State compensation administration by the employer or insurance company soon after the injury occurs. Some States publish descriptions of injuries to young workers from time to time, basing them on actual cases reported in this way to the compensation officials. These stories are particularly valuable when the formal report of the injury has been supplemented by investigation as to the age of the minor, the legality of his employment, the circumstances responsible for his injury, and the degree of disability that is likely to result.

In addition to being one of the basic sources of industrial-injury stories and statistics, the individual report of injury is also valuable in that it furnishes a point at which efforts to prevent similar injuries to minors in the future can best begin. Some States now try to accomplish this goal by having all incoming reports of injuries to minors reviewed by the several divisions or agencies responsible for the enforcement of various types of protective legislation. The child-labor office examines them in order to verify the age and legality of employment of the injured child and to take necessary action if the work is found to be illegal. The accident reports for minors may also be reviewed, along with those for older workers, by the persons responsible for enforcing safety and industrial-health laws, who also take remedial action, if necessary. The workmen's compensation administrators see that the proper amount of compensation is paid, including penalty compensation for illegal employment, if it is due. The statistical services compile the tabulations needed by the various agencies or divisions involved and, in cooperation with them, interpret the resulting data for their use and for that of the public.

Each of the 47 States having a workmen's compensation law possesses the fundamental data for studying its own experience in regard to industrial injuries to minors. By utilizing the statistical and other information latent in the individual accident reports, each State can find out what problems are involved, and what solution is indicated. Intelligent and effective action can then be taken to save the lives and limbs of young workers.

Stories Behind the Statistics

Ten-year-old hurt in fall from bakery wagon.—A 10-year-old boy employed as part-time helper on a bakery wagon fell to the pavement, injuring his hand, one foot, and both shoulders. His wages were reported as $1 a week. It was expected that he would be disabled for 3 or 4 weeks. His employment was illegal under the child-labor law of his State.

Killed by pulp rolls.—A 16-year-old boy was instantly killed when he was caught between the rolls on a pulp machine.

Crushed between trucks.—A 15-year-old boy was severely injured by being crushed between two trucks at a plant where he was employed as a driver.

Arm mangled in laundry machinery.—A boy aged 16 years had his arm mangled in an extractor in a laundry.

Portable sawmill accident.—A 15-year-old boy was seriously injured when caught in the tractor belt of a portable sawmill operating on a farm.

Death from skull fracture.—A 17-year-old high-school boy was injured while loading cars at a steel plant, but insisted he was not seriously hurt. He had, however, sustained a fracture of the skull and was fatally stricken at the high school while waiting to receive his diploma.

Killed in shipyard.—A 16-year-old boy employed as a laborer by a shipbuilding company was helping repairmen work on his slotting machine, which was out of order, and for this purpose got under the machine. A plant "jitney" struck a stack of 500-pound castings near the machine and knocked them over on the boy. He was killed instantly.

Meat-grinder accident causes loss of hand.—A 15-year-old boy employed in the meat department of a chain store lost the greater portion of one hand in a meat grinder. Police and hospital staff men worked for 2 hours cutting away the head of the meat grinder to release the boy's four hopelessly crushed fingers, which were later amputated. His work on the meat grinder was a violation of the child-labor law of his State.

Thirteen-year-old farm hand injured in fall from thresher.—A 13-year-old boy employed as a farm hand by a threshing contractor fell from a thresher and broke his collar bone. His employment was illegal under the child-labor law of his State, and his employer had to pay him treble the normal compensation rate on this account.

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CHILDREN AROUND THE WORLD

BRAZIL

Welfare Services for Juvenile Delinquents

Under a recent decree, the "Service of Assistance to Minors" (Serviço de Assistência a Menores), a unit of the Ministry of Justice and the Interior of Brazil, has been reorganized, and its functions have been expanded.

The Service has heretofore been investigating the cases of children brought before the juvenile court in Rio de Janeiro and maintaining institutions for them. Under the new decree the facilities of the Service are made available to any juvenile court in the country. The Service is to study the cases of children referred to it by juvenile courts; to provide physical and mental examinations and treatment for them; to watch their progress in institutions and to take measures for their rehabilitation after discharge from institutions; to supervise public and private institutions for neglected and delinquent children; and to study the causes of neglect and delinquency.

Two new institutions, one of them a hospital, have been added to those previously maintained by the Service of Assistance to Minors.

The Service will also conduct courses for the training of its staff.

Several new positions are to be created, and appropriations for the salaries are to be included annually in the budget of the Ministry of Justice and the Interior.

Diario Oficial, Rio de Janeiro, September 13, 1944.

MEXICO

Institution for Tuberculous Children in Mexico City

The "First Shelter for Tuberculous Children" has just been opened in Mexico City. This institution, established by the National Committee Against Tuberculosis, is intended for the temporary care of certain categories of children discharged from the Children's Hospital after treatment for tuberculosis. Among others it will accommodate children in the "post-tuberculosis period" who need to be taught habits of hygiene before they are returned to their homes, also children who may still be a source of infection to members of their families, and children who may be in danger of being reinfected in their homes.

In connection with the opening of the institution the National Committee Against Tuberculosis has inaugurated a campaign for the sale of seals and certificates.

El Popular, Mexico City, March 15, 1945.

Plans for Low-Cost Housing

Plans for low-cost housing have been made in Mexico City by representatives of the Institute of Social Insurance, which administers the law on social insurance, of the Federal Department of Health and Welfare, and of other Government departments. The Institute will finance construction of houses to meet the urgent need of workers' families.

El Popular, Mexico City, April 9, 1945.

Newsboys and Bootblacks Taught To Read and Write

In response to a recent appeal for the eradication of illiteracy, made by the President of Mexico to the people of that country, the Federal Department of Labor and Social Welfare has formulated a program to teach reading and writing to newsboys, bootblacks, and other boys engaged in street trades. The boys will be taught by teachers employed in the institutions of the Department of Labor and Social Welfare. The teachers are to be organized in groups of five, each group to be directed by one of its members. Records are to be kept of the work.

Special attention is to be given to Mexico City and its surrounding territory, but the work will be gradually extended to other industrial localities.

Trabajo y Previsión Social, Mexico City, September 1944.

CHILE

First Pan American Congress of Social Service

The First Pan American Congress of Social Service will be held in Santiago, Chile, in September 1945. The time has been planned to coincide with the twentieth anniversary of the founding of the "School of Social Service of the Board of Public Welfare of Santiago", the first school of social service in the Latin-American nations.

The agenda of the Congress includes such subjects as social-service training and social service in child welfare, industry, and rural localities.

The Congress will be held under the auspices of the Ministry of Health of Chile.

Boletín No. 1 del Primer Congreso Panamericano de Servicio Social.

RUSSIA

Administration of Law on Mothers' Aid

For the administration of a law passed July 8, 1944, which provides for increased financial aid to mothers and for an extension of maternal and child-health services, a Federal bureau has been established in Moscow in the People's Commissariat of Finances of the U. S. S. R. Six thousand branches of the bureau have been organized throughout the country. Action on the mother's application for aid is reported to be taken by the municipal authorities within 2 weeks from the time of its receipt.

Similar bureaus have also been established in the Baltic republics recently freed from the Germans.

Izvestia, Moscow, March 4, 1945.

Parent Education

Courses of lectures for parents have been given in many cities and rural districts of the Don Province, U. S. S. R. Exhibits on child training have been set up in clubs and public reading rooms.

Pravda, Moscow, December 18, 1944.

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